COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Abridged Implementation Plan – Not for budgeting or contracting purposes

CHART Phase 2:

Implementation Plan

Beth Israel Deaconess Hospital - Milton

HPC approval date: September 18, 2015

Last modified: June 23, 2016

Version: 3

Introduction

This Implementation Plan details the scope and budget for Beth Israel Deaconess Hospital – Milton's ("Contractor") Award in Phase 2 of the Health Policy Commission's (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Award Contract, including the Phase 2 Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Terms & Conditions or the Phase 2 Request for Proposals (RFP). In addition to capitalized terms, the Implementation Plan may include other acronyms and/or abbreviations whose meaning is understood by Contractor and the HPC in the context of the Implementation Plan. If there is disagreement concerning the meaning of a term, acronym, or abbreviation, the HPC's interpretation shall govern.

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Key personnel

Name	Title	CHART Phase 2 Role
Peter Healy	President and Chief Executive Officer	Executive Sponsor
Ashley Yeats, MD	Vice President Quality and Chief Medical Officer	Clinical Investment Director
Michael Conklin	Vice President Finance and Chief Financial Officer	Operational Investment Director
Lisa Braude, PhD	Project Manager, CHART	Project Manager
Michael Conklin	Vice President Finance and Chief Financial Officer	Financial Designee

Target population

Definition

- All patients* in the ED with a primary behavioral health** complaint

Quantification

- 1,338 BID-Milton ED BH patients per year

*Target population definition includes all payers ,excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

**All behavioral health disorders (ICD-9 290-319 excluding ICD 290, 305.1, and 317-319).

Aim Statement

Primary Aim Statement

Reduce excess ED boarding by 40% for long stay behavioral health patients* by the end of the 24 month Measurement Period.

Secondary Aim Statement**

Reduce 30-day ED revisit rate by 20% for ED patients with a primary BH diagnosis by the end of the 24 month Measurement Period.

* Long stay ED behavioral health patients are defined as patients with a primary BH diagnosis and a length of stay greater than eight (8) hours. "Excess boarding" describes the length of stay greater than four (4) hours.

** Your secondary aim statement is a performance measure only and is not tied to Achievement Payment.

Baseline performance – ED utilization reduction

		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.
All	All ED Visits	2223	1984	2279	2338	2437	2322	2328	2287	2291	2266	2128	2388	2273
	All ED Revisits	254	266	332	318	322	306	300	301	295	248	273	312	297
	Revisit Rate	11%	13%	14%	14%	13%	13%	13%	13%	13%	11%	13%	13%	13%
	LOS (min)	176	180	190	187	169	162	160	155	153	154	142.5	159	161
Target Pop ICD-9 290-319	Target Pop ED Visits	108	113	115	122	111	111	113	100	116	116	106	110	112
	Target Pop ED Revisits	12	18	14	14	20	14	19	22	18	16	18	17	17
	Revisit Rate	11%	16%	12%	11%	18%	13%	17%	22%	16%	14%	17%	15.5%	15%
	LOS (min)	274.5	273	269	267	260	278	235	255.5	299	255	249	280	264*

*LOS (min) represents the median LOS per month, thereby eliminating outliers.

Baseline performance – ED utilization reduction

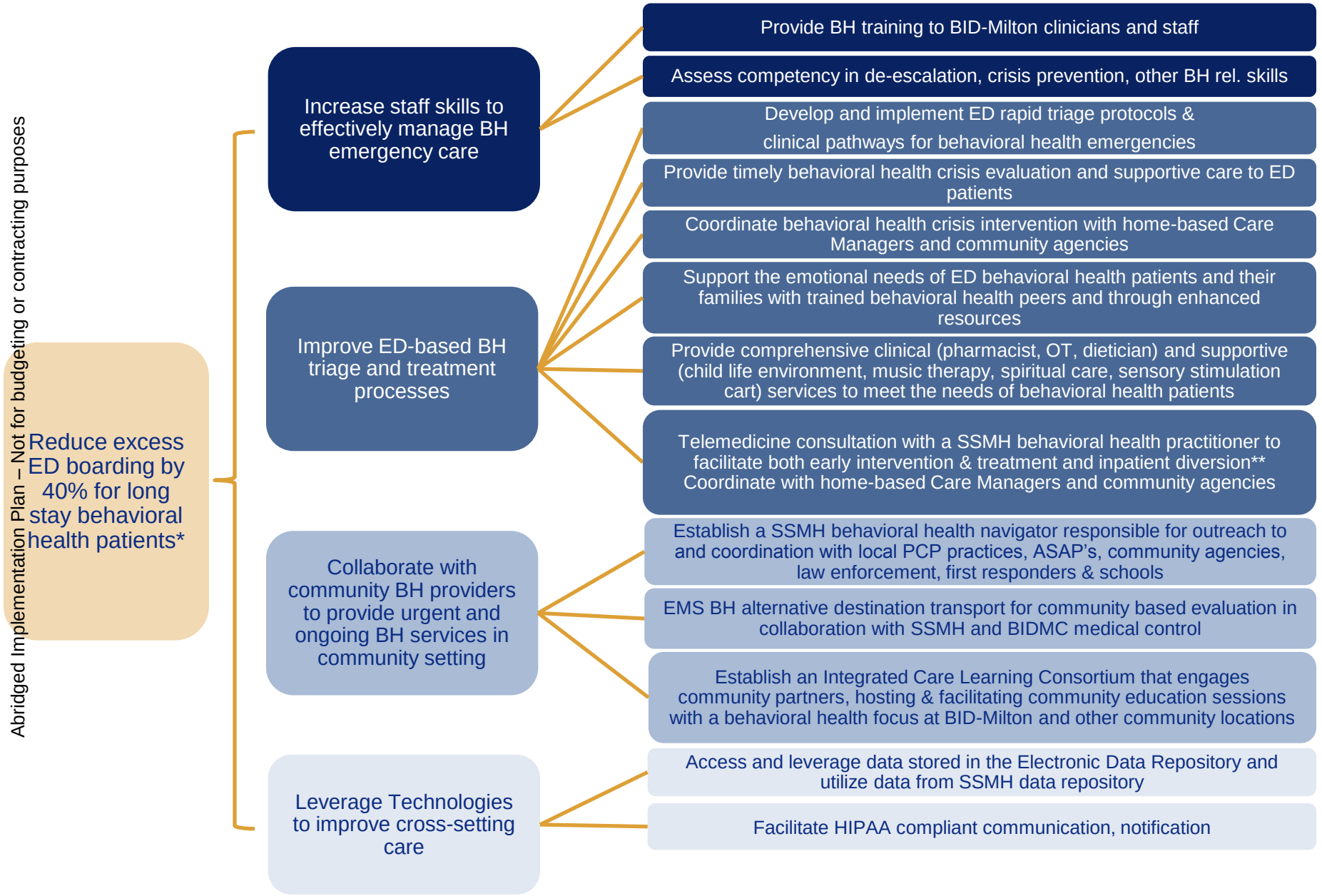
		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.
All	All ED Visits	2223	1984	2279	2338	2437	2322	2328	2287	2291	2266	2128	2388	2273
	All ED BH visits (ICD 290-319)	108	113	115	122	111	111	113	100	116	116	106	107	112
	% ED BH Visits	4.9%	5.7%	5.0%	5.2%	4.6%	4.8%	4.9%	4.4%	5.1%	5.1%	5.0%	4.5%	5.0%
2nd Target Pop ICD-9 290-319 ED Total LOS > 8 hours	# ED Visits	30	29	29	34	23	34	25	24	32	25	16	37	29
	Total LOS hours (9603.7 hrs)	1113.1	903.7	1273.7	864.6	584.8	736.6	861.4	485.2	675.5	684.5	430.9	990.0	800.3
	Total Long Stay Boarding hours: Total LOS minus 4 hours/pxt (8251.7 hrs)	993	788	1158	729	493	601	761	389	548	584	367	842	688

Estimated monthly impact

	Current Average Monthly LOS	Target Reduction in BH LOS	Post CHART-funded Program ED BH LOS	New ED BH LOS
40 % reduction of ED BH LOS	688 hrs	0.4*688 = 276 h	=688 - 276 = 412 h	412 h

	Current community evaluations	New expected # of evaluations
SSMH evals	7751, which = 324 per 1000 evals	1.2*342 = 410 per 1000

Driver Diagram



*Target population definition includes all payers ,excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab
**In collaboration with appropriate community partners

Service model

Narrative description

In partnership with South Shore Mental Health (SSMH), Beth Israel Deaconess Hospital-Milton (BID-Milton) proposes to implement an integrated behavioral health (BH) initiative that maximizes appropriate hospital use and improves hospital-wide and community processes to reduce waste while improving quality and safety for the communities served. The model will increase access to BH services for ED patients, reduce the incidence of BH crises, increase community management of BH crises, reduce BH transfers to inpatient settings, improve the timeliness and quality of care available to BH ED patients, and improve the experience of ED care for all patients served. Key elements of the model include: 1) Swift identification and consultation between ED and BH staff, 2) Intensive stabilization and care management with physicians, nurses, BH professionals, peers, and other supportive services, 3) Expedient linkages to community providers and partners, 4) Community care management, peer support, and BH navigation to prevent readmission into ED; and aligned with 5) ED diversion* for appropriate populations through an alternative destination pilot project and SSMH. Along with the key programmatic elements above, success will be achieved through: 1) Outreach and Linkage to regional partners and community organizations to educate to a better understanding of BH issues and early indicators that additional support may be needed to avert a BH crisis, as well as to the range of existing resources available through SSMH and in the community; 2) Establishment of an Integrated Care Learning Consortium with other key area stakeholders; 3) Hospital Work Force Development to enhance capacity to meet the needs of patients in BH crises in partnership with SSMH and through the introduction of technology to sustain ongoing competency assessment and development; and 4) Enhanced Information Systems and Electronic Communication Capacity, including: i) use of the MA HIway; ii) leveraging an electronic data repository (EDR) to support patient care delivery and performance improvement; and iv) Mobile Phone Secure Text Messaging to facilitate real-time communication between care team members and with patients.

Core services (e.g.: BH Navigation and Home-based Care Management/Peer Support as appropriate) will be delivered for at least seven days from the point of identification in the ED.

*In collaboration with appropriate community partners, contingent upon funding through funded through the recently established FY16 GAA Community Paramedicine Pilot Program. Scope is outside of CHART Phase 2 but will be appropriately aligned and complementary.

Service worksheet

Service Delivered

X Care transition coaching
X Case finding
X Behavioral health counseling
X Engagement
X Follow up
X Transportation
X Meals
• Housing
X In home supports
• Home safety evaluation
X Logistical needs
X Whole person needs assessment
X Medication review, reconciliation, & delivery
X Education
X Advocacy
X Navigating
X Peer support
X Crisis intervention
• Detox
X Motivational interviewing
X Linkage to community services
X Physician follow up
• Adult Day Health
X Other: Telehealth

Personnel Type

X Hospital-based nurse
X Hospital-based social worker
X Hospital-based pharmacist
X Hospital-based NP/APRN
X Hospital-based behavioral health worker
X Hospital based psychiatrist
• Community-based nurse
X Community-based social worker
• Community-based pharmacist
X Community-based behavioral health worker
X Community-based psychiatrist
X Community-based advocate
X Community-based coach
X Community-based peer
X Community agency
X Physician
• Palliative care
X EMS
• Skilled nursing facility
• Home health agency
X Other: Child Life Specialist
X Other: Dietician
X Other: OT/Music Therapist

Service Availability

X Mon. – Fri.
X Weekends
X 7days
X Holidays
X Days
X Evenings
X Nights
X Off-Shift Hours: 24/7

Service mix (1 of 2)

Service	By Whom	How Often	For How Long
ED Crisis Assessment	Clinician	Action: Crisis Assessment Frequency: Point of admit into ED and if symptoms escalate while in ED	Time of Intake /reassess while boarding
Psychiatric Consultation	Nurse Practitioner	Action: Telepsych or in-person evaluation Frequency: As indicated by treating clinicians and based on clinical assessment /care algorithms	Duration of ED stay – Initial telehealth consult and reassessment as needed
Supportive care	Social worker, OT, music therapy, spiritual care, sensory stimulation cart	Action: Supportive services Frequency: As indicated by treating clinicians and based on clinical assessment	Over course of ED stay
Peer Counseling	Certified Peer Counselor	Action: Peer Support Frequency: As indicated by treating clinicians and based on clinical assessment	Over course of ED stay
Diet and Nutrition – meal planning	Licensed Dietician	Action: Food Service Frequency: All meals while in ED (at least 3x per day)	Duration of ED stay
Child Life Services – Child/Family Intervention	Child Life Specialist	Action: Child and family support Frequency: As indicated by treating clinicians and based on clinical assessment	Duration of ED stay for pediatric boarders
Navigation from ED to community (pre-discharge from ED)	Hospital Behavioral Health Navigator, Social Worker, Community Crisis Liaison Clinician, Peer Specialist	Action: Care management Frequency: At time of discharge prep from ED	Time of Discharge
Community support and Mental Health Navigation (post-discharge from ED)	Behavioral Health Navigator, Community Crisis Liaison, other target population providers	Action: Care management Frequency: Daily post-discharge to community	For 7 days post-discharge for all patients. Multiple years in SSMH services.

Service mix (2 of 2)

BID-Milton Position	FTE	Contracted Position	FTE	Community Partner - SSMH Position	FTE
Clinical Investment Director	0.10 FTE	Physician Champion (Contracted position)	0.12 FTE	SSMH Behavioral Health Initiative Manager	0.25 FTE
Operational Investment Director	0.10 FTE	Child Life Specialist (Contracted position)	Ad Hoc	SSMH BH Nurse Practitioner (Yr 2)	Ad Hoc
Director of Care Integration	1 FTE	Music Therapist (Contracted position)	Ad Hoc	SSMH BH Navigator	1.0 FTE
Project Manager	1 FTE	Chaplain	Ad Hoc	Behavioral Health Crisis Clinician (Yr 1)	1.0 FTE
IT Analyst (1/2 time spent on Enabling Tech support)	1 FTE			SSMH Community Crisis Clinician	0.50 FTE
Financial Analyst	0.10 FTE			IT Analyst	0.50 FTE
Pharmacist	0.20 FTE			Peer Partner	0.30 FTE
Occupational Therapist	0.10 FTE			Budget Analyst	0.10 FTE
Admin Assistant	0.10 FTE			Weekend Behavioral Health Clinician	0.40 FTE
Dietician	0.10 FTE				
RN, ER Nurse Champion	0.20 FTE				

# FTE/units of service hired at my organization	4
# FTE/units of service contracted	4.17 + Ad Hoc

List of providers/community agencies (1 of 2)

Type of Service Provider/Resource	Community Agency Name	New/Existing Relationship
Behavioral Health	South Shore Mental Health	Existing
Behavioral Health	The Quincy Center/Arbour	New
Behavioral Health	South Shore Recovery Home	New
Behavioral Health	Bay State Community Services	Existing
Detox Facility	The Phoenix House/Gavin Foundation	New
Homeless Services	Father Bills	Existing
Health Center	Manet Community Health Center	Existing
Health Center	Neponset Community Health Center (Harbor Health)	New
Health Center	South Cove Community Health Center	New
Behavioral Health	Interfaith Social Services	Existing
Outreach/Engagement	South Shore Elder Services	Existing
Information/Referral	Milton Council on Aging	Existing
Ambulance	Fallon Ambulance Service	Existing
Ambulance	Brewster Ambulance Service	Existing
Psychiatry	Nova Psychiatric	Existing
ACO / Primary Care	Atrius Healthcare (HVMA-Quincy/Braintree, Granite)	Existing
Primary Care	Affiliated Physicians Group	Existing
Primary Care	South Shore Internal Medicine	Existing
Local Health Department	Milton Board of Health	Existing
Local Health Department	Quincy Board of Health	New
Local Health Department	Randolph Board of Health	New

List of providers/community agencies (2 of 2)

Type of Service Provider/Resource	Community Agency Name	New or Existing Relationship
Self-Help (individual and family)	Learn to Cope	Existing
Elder Services	Atria Senior Living	Existing
Elder Services	Harbor Health Services Elder Services Plan (PACE)	New
Elder Services	South Shore Elder Services	Existing
Elder Services	Milton Council on Aging	Existing
School	Randolph Public Schools	Existing
School	Milton Public Schools	Existing
School	Milton Academy	Existing
School	Blue Hills Regional Technical School	Existing
School	Quincy Public Schools	Existing
College	Curry College	Existing
Community Coalition	Milton Drug Abuse Task Force	New
Law Enforcement	Quincy Police Department	Existing
Law Enforcement	Milton Police Department	Existing
Law Enforcement	Randolph Police Department	Existing
Courts	Quincy Drug Court	New
Courts	Quincy Mental Health Court	New
Courts	Norfolk County Veterans Treatment Court	New

Summary of services – All patients in the ED with primary BH complaint

Clinical service and staffing mix – Boarding time reduction

Patient Identification / Acute Care Presentation

1. Patient presents to the ED in behavioral health distress via walk-in or EMS.
2. Patient signs in.
3. Patient data is entered in the Meditech system and new visit record is created.

Hospital-based Processes

1. Patient undergoes medical screening examination by ED provider and nurse.
2. Patient is medically cleared.
3. Patient is cross-checked with SSMH to identify if patient has a current provider, history of ESP assessments, or open DMH case.
4. Patient undergoes psychiatric screening exam by SSMH BH Clinician
5. Patient is screened for high risk for boarding - ED provider and Resource Nurse notified
6. If high risk, patient engages in tele-psychiatric consultation with Nurse Practitioner to assess for medication/de-escalation needs.
7. Psychiatric NP communicates treatment recommendations to ED provider and patient's assigned nurse
8. Patient and environment of care safety assessment
9. ED Team (BH Clinician and ED provider and nurse establish and document ED Care Plan to address clinical, physical, social, and dietary needs.
10. Patient receives services as indicated in ED Care Plan including:
    1. Medication Management (evaluation, reconciliation, dose changes)
    2. Occupational Therapy (music therapy and OT cart)
    3. Clinical Support (Peer Support and BH Clinician)
    4. Dietary Needs (at least three meals per day, plus snacks when hungry)
11. Patient meets with BH Navigator to coordinate services with family and community partners
    1. Follow up treatment plan developed
    2. Placement determination is made: psychiatric hospitalization, crisis stabilization unit, community residential, outpatient-partial treatment day program/release to home, release to home with community care manager/Peer f/u, other disposition.

Patient Disposition

1. Patient is released to disposition location.

Post-Hospital Transitional Care Services

1. Patient is tracked for up to seven days by Community Clinician to ensure continued stability and engagement in services.
2. If patient receives long term treatment services via SSMH, patient is tracked indefinitely throughout engagement in services.

Summary of services – All patients evaluated in the community by SSMH

Clinical service and staffing mix – Boarding time reduction

Patient Identification / Acute Care Presentation

1a. Telephone call comes in to Emergency Service Provider (SSMH) OR
1b. Client walks in to 460 N. Quincy Street requesting an evaluation
2a. If client is self referred, telephone assessment of need, ability to remain safe in the community and any safety issues for the clinical staff
2b. If client is referred by a community provider or family member, adult clients must agree to the evaluation before the referral can be accepted.
3b. If community based evaluation is appropriate then staff is sent (for all children covered through mass health products a team of a parent partner and a masters level clinician are deployed.)
3b. If client does not want a home evaluation or an evaluation where they are currently seated client is offered the option of coming to 460 site for evaluation

Patient Disposition

1. Evaluation responds to need and clients are prioritized
2. If client wishes to return at another time or volume precludes immediate response and client is safe he/she is seen as soon as staff are able.
3. Insurance is verified for eligible placements
4. Treatment care plan is developed, treatment location is secured.
5. Patient is released to disposition location.

Post-Hospital Transitional Care Services

1. Patient is tracked for up to seven days by Community Clinician to ensure continued stability and engagement in services.
2. If patient receives long term treatment services via SSMH, patient is tracked indefinitely throughout engagement in services.

Cohort-wide standard measures – Hospital utilization measures

Data elements	All	Target Population
1. Total Discharges from Inpatient Status (“IN”)		
2. Total Discharges from Observation Status (“OBS”)		
3. SUM: Total Discharges from IN or OBS (“ANY BED”)		
4. Total Number of Unique Patients Discharged from “IN”		
5. Total Number of Unique Patients Discharged from “OBS”		
6. Total Number of Unique Patients Discharged from “ANY BED”		
7. Total number of 30-day Readmissions (“IN” to “IN”)		
8. Total number of 30-day Returns (“ANY BED” to “ANY BED”)		
9. Total number of 30-day Returns to ED from “ANY BED”		
10. Readmission rate ("IN readmissions" divided by "IN")		
11. Return rate (ANY 30-day Returns divided by “ANY BED”)		

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – ED utilization measures

Data Elements	All	Target Population
12. Total number of ED visits	x	x
13. Total number of unique ED patients	x	x
14. Total number of ED visits, primary BH diagnosis		
15. Total number of unique patients with primary BH diagnosis		
16. Total number of ED visits, *any* BH diagnosis	x	
17. Total number of unique patients with any BH diagnosis	x	
18. Total number of 30-day ED revisits (ED to ED)	x	x
19. Total number of 30-day revisits (ED to ED), primary BH diagnosis		
20. Total number of 30-day revisits (ED to ED), any BH diagnosis	x	
21. ED revisit rate	x	x
22. ED BH revisit rate (primary BH diagnosis only)		
23. ED BH revisit rate (any BH diagnosis)	x	
24a. Median ED LOS (time from arrival to departure, in minutes)	x	x
25a.Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25b. Min ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25c. Max ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
26a. Median ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)	x	
26b. Min ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)	x	
26c. Max ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)	x	

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Service delivery measures

Data elements	Target Population
27. Total number of unique patients in the target population	x
28. Number of acute encounters for target population patients	x
29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours	x
30. Total number of contacts for the target population	x
31. Average number of contacts per patient served	x
32a. Min number of contacts for patients served	x
32b. Max number of contacts for patients served	x
33. Number of units of service provided by service modality (including, e.g., phone call, virtual interaction, face to face in office, face to face in home, etc.)	x
34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.)	x
35. Number of units of service provided, by role type (NP, LICSW, Pharmacist, Community Health Worker, Peer)	x
36. Average time (days, months) enrolled in CHART program per patient	x
37. Range time (days, months) enrolled in CHART program per patient	x
38. Proportion of target population patients with care plan	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Payer mix

Data elements	Medicare	Medicaid	Commercial
39. Count of patients in the Target Population	x	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Program-specific measures

Measure	Numerator	Denominator
Avg excess LOS for long stay BH Boarders (goal 40% decrease)	# of long stay boarding hours per month (total LOS minus four (4) hours per ED visit)	# of long stay ED BH visits, with a length of stay of eight (8) hours or more
Total number of primary BH ED visits discharged home	Count of ED visits that were discharged to home	N/A
Total number of primary BH ED visits admit to med/surg	Count of ED visits that were admitted to med/surg	N/A
Total number of primary BH ED visits admit/transfer to psych unit	Count of ED visits that were admitted/transferred to psych unit	N/A
Total number of any BH ED visit discharged to home	Number of ED visits with any diagnosis of BH, that were discharged to home	N/A
Total number of any BH ED visit admit to med/surg	Number of ED visits with any diagnosis of BH, that were discharged admitted to med/surg	N/A
Total number of any BH ED visit admit/transfer to psych unit	Number of ED visits with any diagnosis of BH, that were admitted/transferred to psych unit	N/A
% ESP evaluations in community (goal 20% increase)	% of evaluations (current)	% of evaluations (FY15)
# Behavioral Health Navigator ED, inpatient, PCP office, and phone encounters.	# of encounters by patient (per month)	# of all ED BH patients (per month)
# BH Peer contacts provided in ED	# of contact hours provided per patient (per month)	# of all ED BH patients (per month)
# of psychiatric nurse NP telehealth consultations.	# of encounters by patient (per month)	# of all ED BH patients (per month)
# of NP/Pharmacy encounters for whom medications were changed	# of encounters by patient (per month)	# of all ED BH patients (per month)
# of care plans developed (Care plans developed using Allscripts)	# of care plans (per month)	# of all ED BH patients (per month)

Continuous improvement plan (1 of 2)

1. How will the team share data?	The Core Project Team will meet in a bi-monthly basis to review progress toward implementation, including: patient data, outcomes, and modifications to processes.
2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)?	The PM and Clinical Investment Director will look at data weekly, downloading Meditech reports, reviewing ED patient dashboard data, conversations with ED and SSMH staff, and relevant community partners (e.g.: EMS Provider).
3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)?	The Executive Team will meet every other month to review the CHART project reporting with a focus on hospital policy and process changes necessary to ensure a smooth implementation and sustained efforts. It should be noted that hospital VPs with direct oversight of operations related to CHART 2 activity sit on the Core Project Team, and will therefore be briefed every other week.
4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)?	The front line CHART staff will have a daily "huddle" to review all BH patients in the ED using the standard "ED Huddle Checklist" to ensure all patient needs are met and a care plan is in progress.
5. How often will your community partners review data (e.g., weekly, monthly)?	SSMH will be part of the Core Project Team and will meet daily for the ED Huddle (#4) and bi-monthly for implementation and data sharing meetings (#1).
6. Which community partners will look at CHART data (specific providers and agencies)?	SSMH and EMS Provider Ambulance will be looking at CHART 2 data.
7. Will the quality committee of your board review CHART reporting (e.g., quarterly)?	The Investment Director is the VP of Healthcare Quality and the PM works within the Healthcare Quality Department. It is important to BID-Milton that healthcare quality data are tracked at every step of implementation and sustained efforts. Reporting to the quality committee of the board will occur quarterly.

Continuous improvement plan (2 of 2)

8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)?	**Cohort-Wide**	**Program specific**
	CHART team staff will download, aggregate and analyze data and compile it for the HPC in the required reporting templates.	The PM will ensure measures are collected, tracked and will produce reports.
9. What is your approximate level of effort to collect these metrics?	**Cohort-Wide**	**Program specific**
	It is estimated that it will take approximately 10 hours per month to prepare required reports for the HPC.	It is estimated that it will take approximately 30-40 hours/month to tally/abstract aggregate and analyze data, ensure data integrity, and generate required reports.
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures?	We will be able to report on all Cohort-wide measures that reflect ED utilization. A combination of NPR reporting/EDR abstraction, tally sheets, dashboard automation and abstraction tools will be utilized (BID-Milton/SSMH/EMS Provider).	
11. How will you know when to make a change in your service model or operational tactics?	A PDSA improvement model will be deployed driven by data dashboard metrics. As described in slides 7-9, we will track LOS, patient outcomes, and core metrics through monthly reporting and trending. This will be informed by front line care delivery team PI feedback loops (BID-Milton ED/SSMH/EMS Provider staff) incorporated into the ongoing process improvement effort, with direct senior leadership oversight and accountability.	

Enabling Technologies plan

Functionality	User	Vendor	Cost
Programmer/System Data Analyst (0.5 of time will be dedicated to enabling technology implementation)	BID-M	BID-M employee	Consolidated under Personnel section
Individualized care plans	BID-M, SSMH and other community partners	AllScripts Care Director + IATRICS interface	$123,795
Data Dashboard	BID-M and SSMH	Medisolv	$123,584
Secure Texting	BID-M, SSMH and other community partners	Tiger Text	$11,000
Mass HIway	BID-M and SSMH	Network Synergy	$10,000

Enabling Technologies plan – Q&A

- **How are you going to identify target population patients in real-time?**
  - Patients presenting to BID-Milton with a behavioral health issues will be identified through the ED patient triage process.
  - Patients presenting to SSMH for a psychiatric evaluation will be identified via phone or in-person request for consultation.

- **How will you measure what services were delivered by what staff?**
  - Units of service via discrete field data/assessments from NPR reporting/EDR abstraction and software overlay/billing & accounting (e.g. Medisolv).

- **How will you measure outcome measures monthly?**
  - See above – population of scorecards/dashboards

- **What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?**
  - Hospital EMR

- **Where will individual care plans reside, and what is the plan for making them available on a need-to-know basis 24/7 in the ED, hospital, and ambulatory settings?**
  - We have convened a multi-disciplinary workgroup to develop a "Blueprint for a continuum of care for BH patients in the ED". A part of the work will be the development and multidisciplinary implementation of an ED Care Plan. Components of SSMH's Safety Plan and other plans will be integrated to reflect the needs of patients across the full continuum of care. Ideally, this will be housed in Meditech or on a shared secure system between SSMH and BID-M. This is in process.

- **Do you have a method for identifying what clinical services your target population accesses?**
  - Yes – Hospital EMR ED Registration/EMS Provider EMS Registration/SSMH EMR
    - ADT notification not fully implemented at BID-Milton – pilot with Atrius Health as part of Meaningful Use 2 requirements in Fall 2014

Other essential investments

Other Investment	Budget Required
OT Sensory Cart	$5,000-Yr. 2 In-Kind - includes therapy tactile items, music, arts and crafts, and other de-stressors
Mental Health First Aid Training and Crisis Debrief	$9,000-Provided by SSMH to BID-M staff and community partners
Project Manager Mentorship	$48,000-In-kind from BIDMC
Q-Stream	$25,000-in-kind from BIDMC (online learning platform to support professional development)
Professional Development	$3,000 – Mental Health Legal Conference and training on SUD to focus on care integration and better understanding of substance use disorders for care team
Integrated Care Learning Consortium	$2,000 – to support Consortium events

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	10/1/2015
Post jobs	8/2015
New hires made	11/2/2015
Execute contracts with service delivery partners	10/1/2015
Execute contract with Medisolv/Allscripts	9/25/2015
Behavioral health initiatives support 50% of planned patient capacity	11/2/2015
Behavioral health initiatives support 100% of planned patient capacity	1/1/2015
First test report of services, measures	1/4/2016
Enabling technology – Medisolv/Allscripts testing initiated	12/1/2015
Enabling technology – Medisolv/Allscripts go-live	3/1/2016
Trainings completed, if any [describe these – include multiple lines as necessary] *The Integrated Learning Consortium (ILC) is an integral part of this effort. As such, we will host multiple internal and external learning and development forums throughout the tenure of the project. The "kick off" event of the ILC will take place on 10/7/2015. Mental Health First Aid Training will take place on 11/7, 11/13, and 11/20 – open to the public. Additional forums and speakers are scheduled in 10/2015 and 11/2015. The goal is to host a speaker, forum or brown bag approx. 4-6X per year.	*Ongoing: ILC kick off mtg: 10/2015; 11/2015-MHFA; ongoing throughout tenure of project
First patient seen	10/1/2015
Other important milestones you have identified (e.g., staff/user acceptance/patient satisfaction survey) *Continue to review Press Ganey Surveys; staff satisfaction surveys; convene weekly BH Team work group meetings.	*Ongoing – continuous quality improvement

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
South Shore Mental Health	500 Victory Road Quincy, MA 02171	www.ssmh.org	Sherry Ellis	VP, Crisis and Rehabilitative Services	339-237-7178	sellis@ssmh.org
Allscripts	8529 Six Forks Rd Raleigh, NC 27615	www.allscripts.com	Jacob Elfird	Care Management Sales Executive	919-239-7461	Jacob.elfird@allscripts.com
IATRIC	27 Great Pond Dr. Boxford, MA 01921	www.iatric.com	Julia Courtney	Account Executive-Northeast	978-805-4182	Julia.courtney@iatric.com
Medisolv	10440 Little Patuxent Parkway Columbia, MD 21044	www.medisolv.com	Andy Haslam	Vice President of Sales	443-539-0505	ahaslam@medisolv.com
Tiger Text	2110 Broadway Santa Monica, CA 90404	www.tigertext.com	Scott Zamore	Director of Enterprise Sales	781-835-9552	scott@tigertext.com
HMFP (ED Physician Champion)	375 Longwood Ave. 3rd Fl. Boston, MA 02215	http://hmfp.caregroup.org/index.html	Dr. Cheri Weaver	Harvard medical faculty physician	617-313-1351	Cheri_Weaver@MiltonHospital.org
Music Therapist/OT	Independent contractor		Linda LaSalle	Music Therapist	617-313-1351	Rebecca_blair@milton
Child Life Specialist			TBD			
Chaplain			Anne Millington			